FAMILY MEMBER 3 FIRST NAME M.I. FAMILY MEMBER 3 LAST NAME

DRUG ALLERGIES: (CHECK ALL THAT APPLY) PENICILLIN (01) ☐ ASPIRIN (03) ☐ CODEINE (04) ☐ SULFA (15) ☐
TETRACYCLINE (07) ☐ ERYTHROMYCIN (09) ☐ OTHER:
NO KNOWN DRUG ALLERGIES (00) ☐ BIRTH DATE – – GENDER
PHYSICIAN LAST NAME PHYSICIAN PHONE # – –

FOLD HERE

2. PAYMENT METHOD

PLEASE INCLUDE PAYMENT WITH YOUR ORDER. **DO NOT SEND CASH.**
STANDARD DELIVERY OF YOUR ORDER IS **FREE** AND WILL ARRIVE WITHIN 14 DAYS FROM THE DATE WE RECEIVE YOUR ORDER.

CLIENT ID: ANCHOR/GWL

NOTE: YOUR CREDIT CARD WILL BE CHARGED ACCORDING TO YOUR PRESCRIPTION PLAN. ALL FUTURE ORDERS WILL BE CHARGED TO THIS CREDIT CARD, UNLESS PAYMENT (CHECK) ACCOMPANIES THE ORDER.

CREDIT CARD # EXPIRATION DATE –

CARDHOLDER NAME
PLEASE PRINT NAME AS IT APPEARS ON CREDIT CARD

NOTE: IF PAYING BY CHECK OR MONEY ORDER, PLEASE REFER TO YOUR PRESCRIPTION PLAN MATERIALS FOR COPAY.

CHECK/MONEY ORDER AMOUNT ENCLOSED $.

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3. SIGNATURE REQUIRED

PLEASE CHECK ANY OF THE TWO OPTIONS (IF APPLICABLE) AND SIGN THE FOLLOWING STATEMENT.

☐ I WOULD LIKE MY PRESCRIPTIONS DISPENSED WITH NON-CHILD RESISTANT (EASY OPEN) CAPS.

☐ I REQUEST THAT THIS AND FUTURE ORDERS BE SHIPPED "SIGNATURE REQUIRED" FOR AN ADDITIONAL CHARGE.

I CERTIFY THAT ALL THE INFORMATION ON THIS FORM IS CORRECT, INCLUDING ANY SELECTIONS MADE FOR SENDING MY ORDER "SIGNATURE REQUIRED" OR FOR NON-CHILD RESISTANT (EASY OPEN) CAPS. I PERMIT EXPRESS SCRIPTS INC. TO RELEASE ALL INFORMATION ON THIS FORM CONCERNING PRESCRIPTION ORDERS TO MY PLAN SPONSOR, ADMINISTRATOR OR HEALTH PLAN FOR THE PURPOSE OF PAYMENT, TREATMENT, OR HEALTH CARE OPERATIONS.

4. REVIEW YOUR PRESCRIPTION

TO AVOID DELAYS IN PROCESSING YOUR ORDER:

- **CHECK TO SEE IF THE PATIENT NAME, ADDRESS AND DATE OF BIRTH IS CLEARLY WRITTEN ON THE PRESCRIPTION.** IF NOT, PRINT THE PATIENT'S FULL NAME, ADDRESS, PHONE NUMBER AND DATE OF BIRTH ON THE BACK OF THE PRESCRIPTION.
- **CHECK TO SEE IF THE PHYSICIAN SIGNATURE IS LEGIBLE AND PHYSICIAN PHONE NUMBER IS PRINTED ON THE PRESCRIPTION.** IF NOT, PLEASE CIRCLE THE PHYSICIAN'S NAME ON THE PRESCRIPTION, OR PRINT THE PHYSICIAN NAME AND PHONE NUMBER, INCLUDING AREA CODE ON THE BACK OF THE PRESCRIPTION.

NOTE: WE WILL DISPENSE FDA APPROVED GENERIC MEDICATIONS WHEN ALLOWED BY YOUR PHYSICIAN, SUBJECT TO THE TERMS OUTLINED IN YOUR PLAN.

QUESTIONS ABOUT YOUR PHARMACY BENEFIT?
CALL THE MEMBER SERVICES NUMBER LISTED ON YOUR ID CARD

NEW PATIENT MAIL ORDER FORM

PLEASE COMPLETE ALL PORTIONS OF THIS FORM BY PRINTING IN **ALL CAPITAL LETTERS** USING **BLACK INK.**
IF THERE ARE MORE THAN 3 FAMILY MEMBERS, WRITE THE INFORMATION ON A SEPARATE PIECE OF PAPER.

1. PERSONAL INFORMATION

CARDHOLDER ID NUMBER
(REFER TO YOUR PLAN ID CARD)

CARDHOLDER FIRST NAME M.I. CARDHOLDER LAST NAME

DRUG ALLERGIES: (CHECK ALL THAT APPLY) PENICILLIN (01) ☐ ASPIRIN (03) ☐ CODEINE (04) ☐ SULFA (15) ☐
TETRACYCLINE (07) ☐ ERYTHROMYCIN (09) ☐ OTHER:

NO KNOWN DRUG ALLERGIES (00) ☐ BIRTH DATE – – GENDER

PLEASE PROVIDE A STREET ADDRESS, CERTAIN MEDICATIONS CANNOT BE DELIVERED TO A POST OFFICE BOX.

MAILING ADDRESS

CITY

STATE ZIP CODE –

PHONE # – –

PHYSICIAN LAST NAME PHYSICIAN PHONE # – –

FOLD HERE

FAMILY MEMBER 1 FIRST NAME M.I. FAMILY MEMBER 1 LAST NAME

DRUG ALLERGIES: (CHECK ALL THAT APPLY) PENICILLIN (01) ☐ ASPIRIN (03) ☐ CODEINE (04) ☐ SULFA (15) ☐
TETRACYCLINE (07) ☐ ERYTHROMYCIN (09) ☐ OTHER:

NO KNOWN DRUG ALLERGIES (00) ☐ BIRTH DATE – – GENDER

PHYSICIAN LAST NAME PHYSICIAN PHONE # – –

FOLD HERE

FAMILY MEMBER 2 FIRST NAME M.I. FAMILY MEMBER 2 LAST NAME

DRUG ALLERGIES: (CHECK ALL THAT APPLY) PENICILLIN (01) ☐ ASPIRIN (03) ☐ CODEINE (04) ☐ SULFA (15) ☐
TETRACYCLINE (07) ☐ ERYTHROMYCIN (09) ☐ OTHER:

NO KNOWN DRUG ALLERGIES (00) ☐ BIRTH DATE – – GENDER

PHYSICIAN LAST NAME PHYSICIAN PHONE # – –

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ANCHOR/GWL